FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012328

Facility Name: Apostolic Christian Home of Eureka

Address: 610 West Cruger (Number) Eureka (City) 61530 (Zip Code)

County: Woodford

Telephone Number: (309) 467-2311 Fax # (309) 467-2584

IDPA ID Number: 37-6036029001

Date of Initial License for Current Owners: 16-Feb-66

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Thomas A. Hoffman Telephone Number: (309) 467-2311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Thomas A. Hoffman
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,986	1
2		Skilled Pediatric (SNF/PED)			2
3	38	Intermediate (ICF)	38	13,908	3
4		Intermediate/DD			4
5	10	Sheltered Care (SC)	10	3,660	5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,635	15,391	1,200	23,226	8
9	SNF/PED					9
10	ICF	1,967	10,883		12,850	10
11	ICF/DD					11
12	SC		2,968		2,968	12
13	DD 16 OR LESS					13
14	TOTALS	8,602	29,242	1,200	39,044	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.65%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Apartment, Duplex, Condominium

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 16-Feb-66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 16-Feb-66 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 36 and days of care provided 1,200

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number: Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	290,374	17,172	16,280	323,826		323,826		323,826			1
2	Food Purchase		225,189		225,189		225,189	(15,547)	209,642			2
3	Housekeeping	122,147	20,062	1,981	144,190		144,190	(4,132)	140,058			3
4	Laundry	122,068	14,017	1,726	137,811		137,811		137,811			4
5	Heat and Other Utilities			189,473	189,473		189,473	(32,975)	156,498			5
6	Maintenance	134,064	14,452	47,398	195,914		195,914	(26,415)	169,499			6
7	Other (specify):*											7
8	TOTAL General Services	668,653	290,892	256,858	1,216,403		1,216,403	(79,069)	1,137,334			8
	B. Health Care and Programs											
9	Medical Director			2,100	2,100		2,100		2,100			9
10	Nursing and Medical Records	2,174,503	30,904	174,808	2,380,215	44,695	2,424,910		2,424,910			10
10a	Therapy	74,300	1,529	64,141	139,970		139,970	389	140,359			10a
11	Activities	164,625	6,397	4,899	175,921		175,921	(1,002)	174,919			11
12	Social Services	43,298	404	3,223	46,925		46,925		46,925			12
13	Nurse Aide Training					8,706	8,706	(3,168)	5,538			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,456,726	39,234	249,171	2,745,131	53,401	2,798,532	(3,781)	2,794,751			16
	C. General Administration											
17	Administrative	146,634			146,634		146,634	(18,941)	127,693			17
18	Directors Fees											18
19	Professional Services			39,692	39,692		39,692	(15,135)	24,557			19
20	Dues, Fees, Subscriptions & Promotions			32,443	32,443		32,443		32,443			20
21	Clerical & General Office Expenses	91,309	7,655	50,744	149,708	(164)	149,544	(16,019)	133,525			21
22	Employee Benefits & Payroll Taxes			706,305	706,305		706,305	(9,754)	696,551			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,988	12,988		12,988	(3,775)	9,213			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			128,247	128,247		128,247	(26,477)	101,770			26
27	Other (specify):*											27
28	TOTAL General Administration	237,943	7,655	970,419	1,216,017	(164)	1,215,853	(90,101)	1,125,752			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,363,322	337,781	1,476,448	5,177,551	53,237	5,230,788	(172,951)	5,057,837			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassificatio

Facility Name & ID Number Apostolic Christian Home of Eureka #0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			340,666	340,666		340,666	(81,892)	258,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			11,338	11,338		11,338	(11,338)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					164	164		164			35
36	Other (specify):*											36
37	TOTAL Ownership			352,004	352,004	164	352,168	(93,230)	258,938			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		119,477	5,253	124,730	(53,401)	71,329		71,329			39
40	Barber and Beauty Shops			24,492	24,492		24,492		24,492			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,842	59,842		59,842		59,842			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		119,477	89,587	209,064	(53,401)	155,663		155,663			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,363,322	457,258	1,918,039	5,738,619		5,738,619	(266,181)	5,472,438			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,547)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,596)	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		20.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(245,038)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (266,181)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (266,181)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Relatec											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Home of Eureka COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0012328

CONTACT PERSON REGARDING THIS REPORT Thomas A. Hoffman

TELEPHONE (309) 467-2311 FAX #: (309) 467-2584

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION

A. Square Feet: 42,865 B. General Construction Type: Exterior Brick Frame Protected Ord. & Fire Resistance Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.
List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	63,500	1963	$ 58,945	1
2					2
3	TOTALS	63,500		$ 58,945	3

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		Dec-66	Dec-66	$ 488,404	$ 12,210	40	$ 12,210	$	$ 476,211	4
5	38		Dec-75	Dec-75	605,234	15,091	40	15,131	40	432,331	5
6	11		Aug-94	Aug-94	1,522,126	38,053	39	39,029	976	403,977	6
7	8		Dec-94	Dec-94	226,582	12,413	39	5,810	(6,603)	58,190	7
8				Feb-89	3,512	176	20	176		2,728	8
	Improvement Type**										
9				Dec-67	17,605	440	40	440		16,696	9
10				Dec-68	1,508		20			1,508	10
11				Dec-69	11,406		20			11,406	11
12				Dec-70	8,431		20			8,431	12
13				Dec-71	2,975		20			2,975	13
14				Dec-72	550		5			550	14
15				Dec-77	38,346		20			38,346	15
16				Dec-79	1,260		5			1,260	16
17				Dec-81	4,140		10			4,140	17
18				Dec-82	15,776	770	20		(770)	15,776	18
19				Dec-83	4,826		10			4,826	19
20				Dec-84	8,271		10			8,271	20
21				Dec-85	15,630		20	772	772	15,630	21
22				Dec-86	8,500		10			8,500	22
23				Dec-87	950		19	50	50	900	23
24				Dec-88	69,201	3,460	20	3,460		58,820	24
25	Kitchen Addition			Dec-89	12,677	634	20	634		9,827	25
26	Bldg Improvement			Dec-89	10,281		10			10,281	26
27	Water Heater			Dec-90	2,272		20	114	114	1,691	27
28	Central Air			Dec-90	3,978		10			3,978	28
29	Improve Door			Dec-90	2,235		10			2,235	29
30	Remodeling			Dec-90	503	25	20	25		363	30
31	Sprinkler Heads			Dec-90	1,504	75	20	75		1,100	31
32	Blacktopping			Dec-90	3,000	150	20	150		2,225	32
33	Cubicle Curtain Track			Jan-91	850	43	20	43		599	33
34	Carpeting/Woodwork			Jan-91	795	40	20	40		556	34
35	Key Pads/Door System			Mar-91	2,670	134	20	134		1,843	35
36	Thermo Mixing Valves			Apr-91	3,310	166	20	166		2,276	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioning Unit	Jun-91	$ 3,012	$	10	$	$	$ 3,012	37
38	Wall Air Conditioning Unit	Aug-91	910		10			910	38
39	Patio	Jun-91	2,150	108	20	108		1,467	39
40	Asphalt Parking	May-92	8,938	447	20	447		5,628	40
41	Trees & Shrubs	May-92	403	20	20	20		252	41
42	Radiator Covers	Jan-92	5,500	275	20	275		3,568	42
43	Plumbing Upgrade	Jan-92	2,348	117	20	117		1,517	43
44	Shed	Jun-92	2,000	100	20	100		1,256	44
45	Alarm System	Jun-92	4,520	226	20	226		2,826	45
46	Lock Sets	Nov-92	1,207	60	20	60		725	46
47	Water Heater	Mar-92	10,252		10			10,252	47
48	Air Conditioner	Jun-92	886		10			886	48
49	Air Conditioner	Jul-92	926		10			926	49
50	Air Conditioner	Sep-92	858		10			858	50
51	Drapes and Rods	Nov-92	1,057		10			1,057	51
52	Fireplace Glass	Nov-92	587		10			587	52
53	Air Conditioner	May-93	1,303		10			1,303	53
54	Fountain Lights	Sep-93	1,179		10			1,179	54
55	Exterior Lighting	Mar-93	850	42	20	43	1	507	55
56	Hallway Remodeling	Apr-93	2,383	119	20	119		1,392	56
57	Kitchen Flooring	Jun-93	2,441	122	20	122		1,409	57
58	Office Addition	May-94	57,234	1,431	39	1,468	37	15,661	58
59	Roof	Oct-94	17,577	879	20	879		9,009	59
60	Interior Hallway	Jun-94	7,134	268	10	357	89	7,134	60
61									61
62	Phone System	Jun-94	13,120	492	10	651	159	13,120	62
63	Air Conditioner	May-95	1,158	116	10	116		1,117	63
64	Drapes	Dec-95	529	53	10	53		479	64
65	Remodel	Feb-95	5,366		5			5,366	65
66	Improvements	Apr-95	3,293	329	10	329		3,196	66
67	Roof & Insulation	Jun-95	21,002	1,050	20	1,050		9,979	67
68	Building Improvements	Oct-95	7,787	779	10	779		7,175	68
69	Life Safety Code	Dec-95	21,125	1,056	20	1,056		9,550	69
70	TOTAL (lines 4 thru 69)		$ 3,308,343	$ 91,969		$ 86,834	$ (5,135)	$ 1,731,749	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,308,343	$ 91,969		$ 86,834	$ (5,135)	$ 1,731,749	1
2	Air Conditioner	Feb-96	485	49	10	49		435	2
3	Phone System-Social Service	Feb-96	1,201	120	10	120		1,065	3
4	Air Conditioner	May-96	2,886	289	10	289		2,481	4
5	Water Softner	Jun-96	3,442	344	10	344		2,940	5
6	Social Service Office Remodel	Jan-96	2,750	207	20	138	(69)	1,579	6
7	Life Safety Code	Feb-96	8,113	336	20	406	70	3,263	7
8	Life Safety Door	Mar-96	5,061	253	20	253		2,226	8
9	Front Room Wallpaper	May-96	1,008	101	10	101		875	9
10	Ventilation & A/C System	May-96	5,990	599	10	599		5,145	10
11	Front Room Carpet	May-96	2,432	122	20	122		1,047	11
12	Guttering System	Jun-96	3,355	168	20	168		1,435	12
13	Air Conditioning	Jun-96	9,314	466	20	466		3,982	13
14	Air Conditioning	Aug-96	1,008	50	20	50		419	14
15	Cabinetry in Tub Room	Sep-96	2,945	295	10	295		2,446	15
16	Air Conditioning & Ventilation System	Sep-96	8,942	447	20	447		3,707	16
17	Speaker System	Oct-96	3,798	380	10	380		3,120	17
18	Life Safety Ventilation System	Oct-96	798	40	20	40		328	18
19	Six Air Conditioners	Feb-97	2,882	288	10	288		2,258	19
20	Water Heater	May-97	5,871	587	10	587		4,453	20
21	Wall Fountain	Oct-97	653	65	10	65		466	21
22	Draperys	Oct-97	2,839	284	10	284		2,035	22
23	Smoke Detectors	Jan-97	3,103	310	10	310		2,454	23
24	Carpeting	Oct-97	3,525	176	20	176		1,261	24
25	Hall Remodeling	Oct-97	16,641	832	20	832		5,963	25
26	Five Air Conditioners	Mar-98	2,447	245	10	245		1,662	26
27	Water Heater	Oct-98	2,940	294	10	294		1,828	27
28	Air Conditioner	Nov-98	5,415	542	10	542		3,298	28
29	Room Door Guards	Mar-99	2,139	214	10	214		1,240	29
30	Door Alarm Keypads	Jul-99	2,293	229	10	229		1,252	30
31	Seven Air Conditioners	Jan-99	3,182	318	10	318		1,881	31
32	Kitchen Shelving Units	May-99	2,838	283	10	284	1	1,591	32
33	Three Air Conditioners	Aug-99	1,425	143	10	143		768	33
34	TOTAL (lines 1 thru 33)		$ 3,430,064	$ 101,045		$ 95,912	$ (5,133)	$ 1,800,652	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,430,064	$ 101,045		$ 95,912	$ (5,133)	$ 1,800,652	1
2	Room Door Guards	Dec-99	2,610	261	10	261		1,318	2
3	Seven Air Conditioners	Jan-00	3,626	363	10	363		1,785	3
4	Air Conditioner	Sep-00	1,508	151	10	151		648	4
5	Generator & Building	Jan-00	303,143	7,579	40	7,579		37,272	5
6	Wall Carpet	Jan-00	3,630	363	10	363		1,815	6
7	Carpeting	Mar-00	21,956	2,196	10	2,196		10,438	7
8	Courtyard Improvements	May-00	5,312	306	10	531	225	2,124	8
9	Courtyard improvements	May-99	11,738	1,444	10	1,174	(270)	5,722	9
10	Air conditioner	May-01	632	63	10	63		229	10
11	Lighting	Jul-01	2,233	447	5	447		1,548	11
12	Attached wash stations	Aug-01	849	85	10	85		287	12
13	Hot water heater	Oct-01	939	188	5	188		604	13
14	Counter top	Dec-01	550	55	10	55		170	14
15	Air conditioner	Aug-01	9,725	486	20	486		1,660	15
16	Installation of sinks	Sep-01	1,050	105	10	105		346	16
17	New dumpster door	Mar-02	928	46	20	46		127	17
18	Flooring for 2002 addition and remodel	Dec-02	85,333	4,267	20	4,267		8,534	18
19	2002 addition and remodel	Dec-02	2,247,842	56,196	40	56,196		112,392	19
20	Room designation	Feb-02	627	63	10	63		181	20
21	Water heater	Feb-02	4,147	415	10	415		1,178	21
22	Drapes and blinds for dining, activity, therapy	Dec-02	15,437	1,544	10	1,544		3,088	22
23	Courtyard sprinkler system	Jun-02	8,800	880	10	880		2,274	23
24	Gravel driveway	Jun-02	634	127	5	127		328	24
25	Landscaping for 2002 addition	Dec-02	198,700	9,935	20	9,935		19,870	25
26	Sprinkler system for 2002 addition	Dec-02	9,600	960	10	960		1,920	26
27	Surveillance camera	Feb-03	1,750	350	5	350		643	27
28	Water heater	Feb-03	4,965	496	10	497	1	913	28
29	Signage	Feb-03	895	90	10	90		165	29
30	Valances	Mar-03	662	66	10	66		116	30
31	Electrical work addition	Feb-03	8,185	205	40	205		377	31
32	Addition painting	Mar-03	5,289	132	40	132		232	32
33	Remodel breakroom	Mar-03	3,085	154	20	154		270	33
34	TOTAL (lines 1 thru 33)		$ 6,396,444	$ 191,063		$ 185,886	$ (5,177)	$ 2,019,226	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,396,444	$ 191,063		$ 185,886	$ (5,177)	$ 2,019,226	1
2	Thermostats in addition	Jun-03	560	56	10	56		84	2
3	Steel Doors	Jul-03	1,095	55	20	55		78	3
4	Oxygen room exhaust fan	Aug-03	2,062	52	40	52		69	4
5	Storm sewer work	Jul-03	3,500	350	10	350		497	5
6	Door alert system	Jan-04	1,342	67	10	123	56	123	6
7	Hot water heater	Nov-04	2,977	149	10	25	(124)	25	7
8	Smoke detectors, roller latches, fire window	Jan-04	8,913	398	13	629	231	629	8
9	Life safety, wall repair, carpeting	Feb-04	9,202	317	15	514	197	514	9
10	Handrails	Mar-04	1,472	74	10	111	37	111	10
11	Roofing	May-04	6,500	163	20	191	28	191	11
12	Remodel tubroom, room 121 & 123, hallways	Jun-04	47,702	1,192	20	1,202	10	1,202	12
13	Carpeting room 255-257, office renovations	Nov-04	13,647	341	20	58	(283)	58	13
14	Carpeting rm 251-254 & 258-259, heating & panic door	Dec-04	8,348	242	17		(242)		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,503,764	$ 194,519		$ 189,252	$ (5,267)	$ 2,022,807	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 464,147	$ 58,918	$ 58,918	$	10	$ 180,345	71
72	Current Year Purchases	63,624	3,726	3,726		10	3,726	72
73	Fully Depreciated Assets	800,204					800,204	73
74								74
75	TOTALS	$ 1,327,975	$ 62,644	$ 62,644	$		$ 984,275	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	91 Chevy Van	33728	$ 24,464	$	$	$	10	$ 24,464	76
77	Maintenance	86 Chevy Pickup	May-96	8,159	1,145	816	(329)	10	5,507	77
78	Maintenance	98 Dodge Truck	Feb-99	13,280	1,328	1,328		10	7,844	78
79	Patient Transport	99 Ford Chassis	Jun-99	49,239	4,924	4,924		10	27,480	79
80	TOTALS			$ 95,142	$ 7,397	$ 7,068	$ (329)		$ 65,295	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,985,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 264,560	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 258,964	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,596)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,072,377	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments	$ 368,241	$ 11,377	$ 337,720	86
87	Condos	1,376,889	35,483	519,096	87
88	Duplexes	899,801	29,246	626,812	88
89	Rental Units	328,707			89
90	Land	236,950			90
91	TOTALS	$ 3,210,588	$ 76,106	$ 1,483,628	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	$ 8,731	92
93			93
94			94
95		$ 8,731	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ #REF!	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ #REF!	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ #REF!	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ #REF!	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ #REF!	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 164 Description: Copy machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	1,650	3,200	2,868	7,718
8	Nurse Aide Competency Tests		688	300	988
9	TOTALS	$ 1,650	$ 3,888	$ 3,168	$ 8,706
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,538			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 3,168

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	6
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	182	$ 13,183	$	182	$ 13,183	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		19	938		19	938	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		61	3,063		61	3,063	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				40,757		40,757	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): Medical Supplies	39.2					30,572		30,572	13
14	TOTAL			$	262	$ 17,183	$ 71,329	262	$ 88,512	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number: Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,231,823	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	413,830		3
4	Supply Inventory (priced at FIFO)	36,115		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,753		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 1,735,521	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	629,194		13
14	Buildings, at Historical Cost	8,815,767		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,700,993		16
17	Accumulated Depreciation (book methods)	(4,607,984)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Process	8,731		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 6,546,701	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 8,282,222	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (98,138)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(227,733)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(1,911)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(37,938)		36
37	Life Lease Deferred Income	(254,329)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ (620,049)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Lease Equity	(1,990,626)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ (1,990,626)	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ (2,610,675)	$	46
47	TOTAL EQUITY(page 18, line 24)	$ (5,671,547)	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ (8,282,222)	$	48

*(See instructions.)

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reportec	$ 5,402,361	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 5,402,361	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	269,186	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	$ 269,186	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	$ 5,671,547	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All require classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,534,975	1
2	Discounts and Allowances for all Levels	(432,718)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 5,102,257	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	143,508	6
7	Oxygen	12,004	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 155,512	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	24,379	13
14	Non-Patient Meals	15,547	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,789	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	786	19
20	Radiology and X-Ray		20
21	Other Medical Services	116,498	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 214,999	23
	D. Non-Operating Revenue		
24	Contributions	257,669	24
25	Interest and Other Investment Income***	14,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 272,639	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,753	28
28a	Non-Care Facility	255,645	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 262,398	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 6,007,805	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,216,403	31
32	Health Care	2,745,131	32
33	General Administration	1,216,017	33
	B. Capital Expense		
34	Ownership	352,004	34
	C. Ancillary Expense		
35	Special Cost Centers	149,222	35
36	Provider Participation Fee	59,842	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 5,738,619	40
41	Income before Income Taxes (line 30 minus line 40)**	269,186	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ 269,186	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 57,548	$ 27.67	1
2	Assistant Director of Nursing	2,080	2,080	46,136	22.18	2
3	Registered Nurses	19,730	21,454	507,542	23.66	3
4	Licensed Practical Nurses	20,241	22,207	381,750	17.19	4
5	Nurse Aides & Orderlies	89,297	98,100	1,181,527	12.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,636	5,059	74,300	14.69	8
9	Activity Director	1,401	1,665	21,786	13.08	9
10	Activity Assistants	15,125	16,610	142,839	8.60	10
11	Social Service Workers	3,059	3,034	43,298	14.27	11
12	Dietician					12
13	Food Service Supervisor	2,886	2,898	44,406	15.32	13
14	Head Cook	6,786	7,341	67,821	9.24	14
15	Cook Helpers/Assistants	8,776	9,437	85,006	9.01	15
16	Dishwashers	10,986	11,852	93,141	7.86	16
17	Maintenance Workers	7,017	7,527	122,338	16.25	17
18	Housekeepers	12,776	13,760	118,015	8.58	18
19	Laundry	12,045	13,375	122,068	9.13	19
20	Administrator	1,811	1,811	77,140	42.60	20
21	Assistant Administrator					21
22	Other Administrative	7,727	8,439	64,318	7.62	22
23	Office Manager	1,811	1,811	50,553	27.91	23
24	Clerical	1,587	1,747	14,416	8.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,857	252,287	$ 3,315,948 *	$ 13.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	181	$ 8,184	1.3	35
36	Medical Director	12	2,100	9.3	36
37	Medical Records Consultant	24	1,440	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	3,120	10.3	39
40	Physical Therapy Consultant	165	8,238	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,907	11.3	44
45	Social Service Consultant	60	3,107	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	514	$ 28,095		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	182	$ 6,319	10.3	50
51	Licensed Practical Nurses	1,025	34,343	10.3	51
52	Nurse Aides	5,581	101,317	10.3	52
53	TOTAL (lines 50 - 52)	6,788	$ 141,979		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas A. Hoffman	Administrator	-0-	$ 88,583
Kim Joos	Business Manager	-0-	58,051
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 146,634

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heinald Banwart	Accounting	$ 2,063
J.L. Hubbard Insurance	Surety Bond	240
Robert Rein, CPA	Consulting	5,315
Schiff Hardin LLP	Attorneys	16,840
Husch & Eppenberger	Consulting	100
Adjustment		15,135
Rounding		(1)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 39,692

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,876
Unemployment Compensation Insurance	
FICA Taxes	241,505
Employee Health Insurance	330,272
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis Immunization	680
Employee Life/Disability	3,591
Employee Physicals	3,730
Uniform Allowance	
Tax Deferred Annuity	65,170
Non-Care Employee Benefits	(9,273)
TOTAL (agree to Schedule V, line 22, col.8)	$ 696,551

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 35
Advertising: Employee Recruitment	16,206
Health Care Worker Background Check	550
(Indicate # of checks performed 42)	
Life Services Network Dues	6,685
Wellspring Innovative Solutions	4,200
Journal Star & Pantagraph Newspaper	1,032
Nursing Manuals & Oth Subscriptions	1,951
Other Membership Dues \ Licenses	1,784
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,443

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
	(3,775)
In-State Travel	4,489
Seminar Expense	8,499
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,213

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number: Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network Dues 6,685

(3) Did the nursing home make political contributions or payments to a politica action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 9

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 48,148 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ 59,842
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? Yes Indicate the amount. $ 15,547

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.